

## **950 CREDENTIALING AND RECREDENTIALING PROCESSES**

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-10-112, A.A.C. R9-10-114; 42 CFR 438.68(c)(1)(viii), 42 CFR 438.206 (c)(3), 42 CFR 438.214(b)(1); AHCCCS template, Exhibit 950-1; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Credentialing and Re-credentialing Denials; Credentialing Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

This policy covers temporary/provisional credentialing, credentialing, and recredentialing policies for both individual and organizational providers. The credentialing and recredentialing policies must address all providers, including but not limited to acute, primary, behavioral, and substance use disorders [42 CFR 438.214(b)(1)]. The Administrative Services Subcontractors (AdSSs) must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing the AdSS must follow the guidelines located in the Contract.

The AdSS must submit a Quarterly Credentialing Report, 30 days after the end of the quarter, using the AHCCCS template, Exhibit 950-1.

### **Credentialing Individual Providers**

The AdSS must have a written process and a system in place for credentialing and recredentialing providers included in its contracted provider network. Providers who are not licensed or certified must be included in the credentialing process.

- A. Credentialing and recredentialing must be conducted for all providers providing care and services to members eligible for the Division. The AdSS may choose to delegate credentialing to an organizational provider according to requirements outlined in Division Medical Policy Manual, Policy, 910. Credentialing and recredentialing must be completed for at least the following provider types:
1. Physicians (Medical Doctor [MD])
  2. Doctor of Osteopathic Medicine [DO]
  3. Doctor of Podiatric Medicine (DPM)
  4. Nurse practitioners
  5. Physician Assistants
  6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
  7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
  8. Affiliated Practice Dental Hygienists

9. Psychologists
  10. Optometrist
  11. Certified Registered Nurse Anesthetist
  12. Occupational Therapist
  13. Speech and Language Pathologist
  14. Physical Therapists
  15. Independent behavioral health professionals who contract directly with the AdSS and other non-licensed or certified providers that provide behavioral health services including, including:
    - a. Licensed Clinical Social Worker (LCSW)
    - b. Licensed Professional Counselor (LPC)
    - c. Licensed Marriage/Family Therapist (LMFT)
    - d. Licensed Independent Substance Abuse Counselor (LISAC)
  16. Board Certified Behavioral Analysts (BCBAs)
  17. Any non-contracted provider that is rendering services and sees 50 or more members served by the AdSS per contract year
  18. Covering or substitute oral health providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider.

Covering or substitute oral health providers must indicate on the claim form that they are the rendering provider of the care of service.
- B. The AdSS must ensure:
1. Credentialing and recredentialing processes do not discriminate against a provider who serves high-risk populations or who specializes in the treatment of costly conditions.
  2. Compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.
- C. If the AdSS delegates to another entity any of the responsibilities of credentialing/recredentialing that are required by this Policy, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of this Chapter regarding delegation.

- D. Written policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing providers. The policies and procedures must be reviewed and approved by the Contractor's executive management, and
1. Reflect the direct responsibility of the local Medical Director, or in the absence of the local Medical Director, another local designated physician to:
    - a. Act as the Chair of the Credentialing Committee
    - b. Implement the decisions made by the Credentialing Committee
    - c. Oversee the credentialing process.
  2. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions.
  3. Describe the methodology to be used by the AdSS staff and the local AdSS Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, prior to the presentation to the Credentialing Committee for evaluation.
- E. The AdSS must maintain an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider. Each file must include all of the following:
- a. The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by the signature on the application
  - b. Information gained through credentialing and recredentialing queries
  - c. Utilization data, quality of care concerns, grievances, performance measure rates, value based purchasing results and level of member satisfaction
  - d. Any other pertinent information used in determining whether or not the provider met the AdSS's credentialing and recredentialing standards.
- F. Credentialed providers must be entered/loaded into the AdSS's claims payment system with an effective date of no later than the date the provider was approved by the Credentialing Committee approval.
- G. For Locum Tenens, the AdSS must verify the status of the physician with the Arizona Medical Board and national databases.

## **Initial Credentialing**

The AdSS must use the Arizona Health Plan Association's Credential Verification Organization (CVO) as part of the credentialing process. At a minimum, policies and procedures for the initial credentialing of providers, as required by the Policy must include:

- A. Written application to be completed, signed and dated by the provider, that attests to the following elements:
  1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
  2. Lack of present illegal drug use
  3. History of loss of license and/or felony convictions
  4. History of loss or limitation of privileges or disciplinary action
  5. Current malpractice insurance coverage
  6. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation must be included in the provider's credentialing file)
  7. Minimum five-year work history, or total work history if less than five years.
- B. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.
- C. Verification from primary sources of:
  1. Licensure or certification
  2. Board certification, if applicable, or highest level of credentials attained
  3. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Professional Counselor (LPC)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Independent Substance Abuse Counselor (LISAC).

Primary source verification of:

  - a. Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE)
  - b. A review of complaints received and disciplinary status through AZBBHE.

- D. For credentialing of Licensed Board Certified Behavioral Health Analysts:
1. Licensure by the Arizona Board of Psychologist Examiners
  2. A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners.
  3. Continuing Education requirements
    - a. BCBAs credentialed under a 3-Year Cycle: 36 hours every 3 years (3 hours in ethics and professional behavior)
    - b. BCBAs credentialed under a 2-Year Cycle: 32 hours every 2 years (4 hours in ethics for all certificates; 3 hours in supervision for supervisors)
  4. Continuing Education courses (see table below)
    - a. BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCaBAs) or Registered Behavior Technicians (RBTs) must obtain specific training in order to do so. These individuals must also obtain 3 Continuing Education Units (CEUs) on supervision in every certification cycle.
    - b. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.

| <b>TYPE</b> | <b>DESCRIPTION</b>   | <b>LIMIT</b>                          | <b>CEUs</b>                       |
|-------------|--|---------------------------------------|-----------------------------------|
| 1           | College or university coursework<br>CE issued by approved continuing education (ACE) providers | None – all CE can come from this type | 1 hour of instruction = 1 CEU     |
| 2           | Non-approved events  | None – all CE can come from this type | 50 minutes of instruction = 1 CEU |
| 3           | Instruction of Type 1 or Type 2  | 25% can come from this type*          | 1 hour = 1 CEU                    |
| 4           | CE issued by the BACB directly   | 50% can come from this type*          | 1 hour of instruction = 1 CEU     |
| 5           |  | 25% can come from this type*          | Determined by BACB                |

| TYPE | DESCRIPTION                                | LIMIT                                     | CEUs   |
|------|--|---|--|
| 6    | Take and pass the certification exam again | All CE will be fulfilled by this activity | Passing the exam equals 100% of your required CE, except for supervision |
| 7    | Scholarly Activities                       | 25% can come from this type*              | One publication = 8 CEUs<br>One review = 1 CEU                           |

*\*A maximum of 75% of the total required CE may come from categories 3, 4, 5 and 7. At least 25% must come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.*

- E. BCBA's providing supervision of individuals pursuing BACB certification or the ongoing practice of BCBA's or RBT's will be required to obtain specific training in order to supervise. These individuals will also be required to obtain three CEUs on supervision in every certification cycle. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.
1. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A print out of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable.
  2. National Provider Databank (NPDB),
  3. Verification of the following:
    - a. Minimum five year history of professional liability claims resulting in a judgment or settlement
    - b. Disciplinary status with regulatory Board or Agency
    - c. Medicare/Medicaid sanctions, and exclusions, and terminations for cause
    - d. State sanctions or limitations of licensure

4. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/Office of the Inspector General (OIG) immediately in accordance with AdSS Operations Manual Policy 103.
  - a. Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) <http://oig.hhs.gov/fraud/exclusions.asp>, and
  - b. The System of Award Management (SAM) [www.sam.gov](http://www.sam.gov) formerly known as the General Services Administration (GSA)
- F. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.
- G. Initial site visits for Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) applicants must include but are not limited to verification of compliance with the following:
  1. Vaccine and drug storage regulations
  2. Emergency and resuscitation equipment policy
  3. Americans with Disabilities Act requirements [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]
- H. The AdSS must ensure that network providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities [42 CFR 438.206(c)(2)(3)]. AdSS must also ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)].
- I. The AdSS must conduct timely verification of information, as evidenced by approval (or denial) of a provider within 90 days of a receipt of complete application. The AdSS must send a notification to the provider and load all required information in to AdSS's system within 30 days of Credentialing Committee approval in order to allow payment to the provider for services. The effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.
- J. The AdSS must have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application, attestation or Curriculum Vitae (CV).
- K. AdSS providers including licensed or certified behavioral health providers may be subject to an initial site visit as part of the credentialing process.

### **Temporary/Provisional Credentialing**

The AdSS must have policies and procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), are credentialed using the temporary or provisional credentialing process, even if the provider does not specifically request their application be processed as temporary or provisional.

The AdSS must follow the "Initial Credentialing" guidelines when granting temporary or provisional credentialing to:

- Providers in a Federally Qualified Health Center (FQHC)
- Providers in a FQHC Look-Alike organization
- Hospital employed physicians (when appropriate)
- Providers needed in medically underserved areas
- Providers joining an existing, contracted oral health provider group
- Covering or substitute providers providing services to members during a provider's absence from the practice.

The AdSS has 14 calendar days from receipt of a completed application, accompanied by the minimum documents specified in the section, in which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the AdSS's information system to allow payment to the provider effective the date the provisional credentialing is approved.

In situations where a covering or substitute provider must be used by a contracted provider and is approved through the temporary/ provisional credentialing process, the AdSS must ensure that its system allows payments to the covering/substitute provider effective the date of the notification was received from the provider of the need for a covering or substitute provider. Covering or substitute providers must meet the following requirements:

- A. Licensure: Provider and employees rendering services to members must be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses must be maintained in good standing.
- B. Restriction of Licensure: Provider must notify the AdSS within two (2) business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts the Provider's ability to practice or provide services.

- C. Professional Training: Provider and all employees rendering services to members must possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to members.
- D. Professional Standards: Provider and employees rendering services to members must provide care and services which meets or exceeds the standard of care and must comply with all standards of care established by state or federal law.
- E. Continuing education: Provider and employees rendering care or services to members must comply with continuing education standards as required by state or federal law or regulatory agencies.
- F. Regulatory compliance: Provider must meet the minimum requirements for participating in the Medicaid program as specified by the state.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that includes:

- A. Reasons for any inability to perform the essential functions of the position, with or without accommodation
- B. Lack of present illegal drug use
- C. History of loss of license and/or felony convictions
- D. History of loss or limitation of privileges or disciplinary action
- E. Current malpractice insurance coverage
- F. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider's credentialing file.

In addition, the applicant must furnish both of the following:

- A. Work history for the past five years, or total work history if less than five years
- B. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

The AdSS must conduct primary verification of the following:

- A. Licensure or certification; a printout of license from the applicable board's official website denoting that the license is active with no restrictions is acceptable.
- B. Board certification, if applicable, or the highest level of credential attained, and
- C. National Provider Data Bank (NPDB) query, including:
  - 1. Minimum five-year history of professional liability claims resulting in a judgment or settlement

2. Disciplinary status with regulatory board or agency
3. State sanctions or limitations of licenses
4. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The local AdSS's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credentialing Committee review, as outlined in this policy, must be completed.

### **Recredentialing Individual Providers**

The AdSS must use the Arizona Health Plan Association's Credential Verification Organization as part of its credentialing process. At a minimum, the recredentialing policies for physicians and other licensed or certified health care providers must identify procedures that address the recredentialing process and include requirements for:

- A. Recredentialing at least every three (3) years
- B. An update of information obtained during the initial credentialing process as required in the Initial Credentialing section of this policy
- C. Verification of continuing education requirements being met
- D. A process for monitoring health care providers specific information, including, but not limited to:
  1. Member concerns, which include grievances (complaints)
  2. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)
  3. Performance improvement and monitoring (e.g., performance measure rates)
  4. Results of medical record review audits, if applicable
  5. Quality of care issues (including trend data)

If an adverse action is taken with a provider, including non-renewal of a contract, the AdSS must report the adverse action and include the reason for the adverse action to the Division's Quality Management Unit within one business day.
  6. Pay for performance and value-driven health care data/outcomes, if applicable
  7. Evidence that the provider's policies and procedures meet Division requirements

8. Timely approval (or denial) by the AdSS's Credentialing Committee within three years from the previous credentialing approval date. Primary Source Verification must also be current, within 180 days, for the Committee's decision.

### **Initial Credentialing of Organizational Providers**

- A. As a prerequisite to contracting with an organizational provider, the AdSS must ensure the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, including policies and procedures for credentialing and recredentialing if delegated to the organizational provider. The requirements described in this section must be met for all organizational providers in its network, including, but not limited to:
  1. Hospitals
  2. Home health agencies
  3. Nursing facilities
  4. Dialysis centers
  5. Dental and medical schools
  6. Freestanding surgical centers
  7. State or local public health clinics
  8. Community/Rural Health Clinics (or Centers)
  9. Air transportation
  10. Non-emergency transportation vendor
  11. Laboratories
  12. Pharmacies

13. Behavioral health facilities, including but not limited to:
  - a. Independent Clinics
  - b. FQHCs
  - c. Community Mental Health Centers
  - d. Level 1 Sub-Acute Facility
  - e. Level 1 Sub-Acute Intermediate Care Facility
  - f. Level 1 Residential Treatment Center (secure and non-secure)
  - g. Community Service Agency
  - h. Crisis Services Provider/Agency
  - i. Behavioral Health Residential Facility
  - j. Behavioral Health Outpatient Clinic
  - k. Integrated Clinic
  - l. Rural Substance Abuse Transitional Agency
  - m. Behavioral Health Therapeutic Home
  - n. Respite homes/providers
  - o. Specialized Assisted Living Centers
  - p. Specialized Assisted Living Homes.
- B. Prior to contracting with an organizational provider, the AdSS must:
  1. Confirm the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement).
  2. Confirm the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The AdSS must state in policy which accrediting bodies it accepts that are in compliance with federal requirements.

3. Conduct an onsite quality assessment if the provider is not accredited. The AdSS must develop a process and use assessment criteria, for each type of unaccredited organizational provider with which it contracts; that must include, but is not limited to, confirmation that the organizational provider has:
  - a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy
  - b. Liability insurance
  - c. Business license  

Centers for Medicare and Medicaid Services (CMS) certification or state licensure review/audit may be substituted for the required site visit if the site visit was within the past three years prior to the credentialing date. In this circumstance, the AdSS must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the AdSS's standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when the AdSS has documented that they have reviewed and approved the CMS criteria and they meet the AdSS's standards.
  - d. In addition, Community Service Agencies must also have:
    - i. A signed relationship agreement with the AdSS whose members they are serving
    - ii. An approved application with the AdSS
    - iii. A signed contract with the AdSS-contracted network provider or with contractor directly as applicable.
    - iv. A description of the services provided that matches the services approved on the Title XIX Certificate
    - v. Fire inspection reports
    - vi. Occupancy permits
    - vii. Tuberculosis testing
    - viii. CPR certification
    - ix. First Aid certification
    - x. Respite providers provide and maintain consistently a signed agreement with an Outpatient Treatment Center.

4. Review and approve the organizational provider through the AdSS's Credentialing Committee.
5. For transportation vendors, review a maintenance schedule for vehicles used to transport members and the availability of age-appropriate car seats when transporting children.

### **Reassessment of Organizational Providers**

The AdSS must reassess organizational providers at least every three years. The reassessment includes the following information, which must be current:

- A. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body, by validating the organizational provider:
  1. Is licensed to operate in the state, and is in compliance with any other state or federal requirements as applicable
  2. Is reviewed and approved by an appropriate accrediting body.

If an organizational provider is not accredited or surveyed and licensed by the state, an on-site review is conducted.
- B. Review of:
  1. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is to be documented) and, if applicable, review of the online "Hospital Compare" or "Nursing Home Compare"
  2. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications
  3. Supervision of staff and required documentation of direct supervision/clinical oversight as required in A.A.C. R9-10-114. This process must include a review of a valid sample of clinical charts
  4. Most recent audit results of the organizational provider
  5. Confirmation that the service delivery address is verified as correct
  6. Review of staff to verify credentials, and that staff meets the credentialing requirements.
- C. Evaluation of organizational provider-specific information such as, but not limited to, the following:
  1. Member concerns which include grievances (complaints)
  2. Utilization management information

3. Performance improvement and monitoring
4. Quality of care issues
5. Onsite assessment.

If an adverse credentialing, recredentialing, or organizational credentialing decision is made, the AdSS must report the adverse action to the Division's Quality Management Unit within one business day.

- D. Review and approval by the AdSS's Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.
- E. The AdSS must review and monitor other types of organizational providers in accordance with their contract.

#### **Notification Requirements - Suspensions and Terminations**

- A. The AdSS must have procedures for prompt reporting in writing to appropriate authorities including the Division's Quality Management Unit, the provider's regulatory board or agency, the Arizona Department of Health Services Licensure Division, and the Office of the Attorney General. The AdSS must report within one business day to the Division's Quality Management Unit deficiencies that result in a provider's suspension or termination from the AdSS's network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS must promptly notify a law enforcement agency, and Adult Protective Services or the Department of Child Safety. The AdSS must have an implemented process to report providers to licensing and other regulatory entities all allegations of inappropriate or misuse of prescribing including allegations of adverse outcomes that may have been avoided should the provider have reviewed the CSPMP and coordinated care with other prescribers.
- B. The AdSS must report to the Division's Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials that are based on quality-related issues or concerns.
- C. The AdSS must indicate in its notification to the Division the reason or cause of the adverse/denial decision and when restrictions are placed on the provider's contract, such as denials or restrictions that are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division Quality Management Unit will refer cases, as appropriate, to the AHCCCS-OIG. The AHCCCS -OIG will conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. The AdSS must:
  1. Maintain documentation of implementation of the procedures
  2. Have an appeal process for instances in which the AdSS places restrictions on the provider's contract based on issues of quality of care and/or service

3. Inform the provider of the Quality Management (QM) dispute process through the QM Department
  4. Notify the Division's Quality Management (QM) within one business day for all reported events.
- D. Have procedures for reporting to the AHCCCS Clinical Quality Management Unit in writing any final adverse action for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A "final adverse action" does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.
- E. Submit to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):
1. Within 30 calendar days from the date the final adverse action was taken or the date when the Contractor became aware of the final adverse action, or
  2. By the close of the Contractor's next monthly reporting cycle, whichever is later.
- F. A final adverse action includes:
1. Civil judgments in federal or state court related to the delivery of a health care item or service
  2. Federal or state criminal convictions related to the delivery of a health care item or service
  3. Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
    - a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation
    - b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise
    - c. Any other negative action or finding by such federal or state agency that is publicly available information,
    - d. Exclusion from participation in federal or state health care programs as specified in current statute
    - e. Any other adjudicated actions or decisions that the Secretary must establish by regulation.

4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision made based on quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the AdSS network, provider termination, provider suspension or an action that limits or restricts a provider.
- G. Notice of an AdSS's final adverse action should be sent to the Division's Quality Management Unit within one business day of the notice.
- H. The AdSS, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the Medicaid Program. Notification to AHCCCS-OIG must be in accordance with AdSS Operations Manual Policy 103 and as specified in Section F3, Contractor Chart of Deliverables. This must include allegations of fraud, waste or abuse that were resolved internally but involved Medicaid funds. The AdSS must also report to the Division, as specified in Section F3, Contractor Chart of Deliverables, any credentialing denials issued by the Credential Verification Organization including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation.
- I. The AdSS must report, within one business day, the following:
1. The name and Tax Identification Number (TIN), as defined in section 7701(A)(41) of the Internal Revenue Code of 1986 (1121)
  2. The name (if known) of any health care entity with which the health care provider, supplier, or practitioner is affiliated or associated
  3. The nature of the final adverse action and whether such action is on appeal
  4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section
  5. The date the final adverse action was taken, its effective date and duration of the action
  6. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and
  7. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/OIG immediately in accordance with AdSS Operations Manual, Policy 103:

- a. The System of Award Management (SAM)/www.sam.gov, formerly known as the Excluded Parties List System (EPLS)
- b. The Social Security Administration’s Death Master File
- c. The National Plan and Provider Enumeration System (NPPES)
- d. The List of Excluded Individuals (LEIE)
- e. Any other databases directed by the Division, AHCCCS or CMS.

**Teaching Physicians and Teaching Dentists**

AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialed by the AdSS in accordance with Division policy as set forth in this policy.

**Credentialing Timeliness**

The AdSS must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the AdSS must divide the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category. The Division has adopted Exhibit 950-1 in the AHCCCS Medical Policy Manual to be used by the AdSS when submitting the Quarterly Credentialing Report to the Division’s Quality Management Unit through the Division’s Compliance Unit.

The standards for processing, are listed by category below.

| <b>Type of Credentialing</b>   | <b>Timeframe</b>  | <b>Completion Requirements</b> |
|--|-------------------|--------------------------------|
| Provisional  | 14 days           | 100%                           |
| Initial  | 90 days           | 100%                           |
| Organizational Credentialing   | 90 days           | 100%                           |
| Recredentialing  | Every Three Years | 100%                           |
| Load Times<br>(Time between Credentialing Committee approval and loading into claims system) | 30 Days           | 90%                            |